



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

Dr. Robert E. Urrea

**Respondent Name**

Texas Mutual

**MFDR Tracking Number**

M4-14-1371-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

January 17, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Dr. Urrea prepared the narrative report in response to a request from the Division of Workers Compensation. Dr. Urrea was asked to respond to questions from an Ombudsman to determine if they could proceed with a hearing."

**Amount in Dispute:** \$100.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "After review of the bill Texas Mutual denied payment of code 99080 for the following reasons. First, code 99080 has a permanent "B" status under Medicare and is not separately paid. Second, Rule 134.120(d) states, "...If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information." However, the requestor implies it is written as "...If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the **insurance carrier** shall reimburse the health care provider for this additional information." Third, section (g) of the same Rule states in pertinent part "Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division." The requestor's DWC-60 packet clearly reflects and Ombudsman with the Office of Injured Employee Counsel is the "requestor" of the report not Texas Mutual and not the division. No payment is due."

**Response Submitted by:** Texas Mutual

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2013	99080	\$100.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §404.002 establishes Office of Injured Employee Counsel administrative attachment to

Texas Department of Workers' Compensation.

3. 28 Texas Administrative Code §134.120 sets out guidelines for reimbursement for medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC – W1- Workers compensation rate fee schedule adjustment
  - CAC – 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
  - CAC – 193 – Original payment decision is being maintained
  - 284 – No allowance was recommended as this procedure has a Medicare status of “B” (bundled).
  - 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions

### **Issues**

1. Is the Office of Injured Employee Counsel part of the Division of Workers' Compensation?
2. Was the definition of narrative report met?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. The respondent in their position stated, “The requestor’s DWC-60 packet clearly reflects and Ombudsman with the Office of Injured Employee Counsel is the “requestor” of the report not Texas Mutual and not the division.” Per Texas Labor Code §404.002 (b), “The office is administratively attached to the department but is independent of direction by the commissioner, the commissioner of insurance, and the department...” The respondent’s position is correct that the Office of the Injured Employee Counsel is not DWC.
2. Per 28 Texas Administrative Code 134.120 (g) Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or equivalent electronic document format. Clinical or progress notes do not constitute a narrative report.
3. Review of the submitted documentation finds the request was not made by the carrier or the Division. No payment can be recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October , 2014  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**